

Title: Provider Screening and Other Enrollment Requirements Under Medicaid and CHIP

Sections: 6401, 6402, 6501 and 6502

State Mandate

Overview: Sections 6401, 6402, 6501, and 6502 of the Patient Protection and Affordable Care Act (ACA) establish a number of new requirements with regard to provider enrollment, program integrity, and prevention and detection of fraud, waste, and abuse in the Medicaid and CHIP programs. These requirements include:

- Provider Enrollment Screening/Provisional Enrollment/Moratoriums (6401)
- National Provider Identifier (NPI) on claims (6401)
- Enrollment Regulations (6401)
- Application Fees (6401)
- Reporting of Adverse Actions to CMS (6401)
- Data Matching and Data Sharing (6402)
- Permissive Exclusions (6501)
- Exclusion Regulations (6502)

Provider Enrollment Screening/Provisional Enrollment/Moratoriums (6401) – The ACA requires potential Medicaid and/or CHIP providers to undergo more rigorous background checks to be completed prior to their enrollment in these programs. This new requirement is intended to avoid enrollment of providers who may be more likely to commit fraud. On-site visits, provisional enrollment, and temporary moratoriums may be imposed on select provider types that have a higher likelihood of committing fraud, waste, and abuse. Examples include durable medical equipment vendors and home health personnel. The expanded screening also includes a \$500 application fee for an institution, such as a hospital or nursing home.

National Provider Identifier (NPI) on claims; Enrollment Regulations; and Application Fees (6401) — All providers eligible for an NPI number must use this number when applying to be Medicaid providers or when submitting Medicaid claims. This will allow for an easier audit trail for retrospective reviews that may be conducted.

Reporting of Adverse Actions to CMS (6401) – The ACA requires a system, yet to be defined, to capture, report and disclose adverse actions taken against providers who are terminated from the Medicaid program. The law requires that a web-based system be established to allow the public and government agencies to search for providers terminated from the Medicaid program. Systems modifications and program resources may be necessary to meet this requirement. Similarly, ACA requires the development of a national system for reporting

criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare and Medicaid Services (CMS).

Data Matching and Data Sharing (6402) – The ACA requires that an expanded set of data elements be captured in the Medicaid Statistical Information System (MSIS) and subsequently reported to CMS. The expanded data set includes all claims and payment information.

Permissive Exclusions (6501) – Providers who knowingly make false statements or misrepresent themselves may be permissively excluded from participating in the Medicaid program.

Exclusion Regulations (6502) – Any provider who has failed to return overpayments, has been suspended or excluded from any state’s Medicaid program or from the Medicare program, or any provider who is affiliated with anyone who has been suspended or excluded from any state’s Medicaid program or from the Medicare program must be terminated or denied enrollment in the State’s Medicaid program.

Targeted Population: While providers will be required to abide by these new rules, States will be required to enforce these requirements. As a result, additional staffing and other resources may be required to adequately enforce these provisions of the ACA.

Fiscal Impact: With regard to Provider Enrollment Screening/Provisional Enrollment/Moratoriums, the fiscal agent¹ will complete preliminary screening of enrollment applications. However, there will be additional cost and utilization of resources associated with the background checks, on-site visits, and the increased oversight that will be needed to ensure compliance with the law. The State’s Medicaid staff will be required to develop policies and procedures to ensure all new providers comply with screening requirements, develop a schedule of re-enrollment, and field calls and inquiries from providers. Nevada’s Medicaid staff will need to act quickly when the regulations are released (projected to be released on October 23, 2010) in order to implement the required changes.

Currently, the use of an NPI is not mandated for select providers. System resources will be needed to provide ad-hoc lists of providers who are eligible to obtain an NPI but do not yet have one. The State Medicaid staff will be tasked with assisting the Fiscal Agent in the development of training, outreach materials, and a process for contacting providers to update

¹ Fiscal Agent defined: Nevada Medicaid currently has a contract with an outside vendor to serve as the state's fiscal agent. Fiscal agent functions include enrollment of providers, processing of Medicaid claims, distribution of Medicaid forms and publications, and other duties as directed by the Division.

their enrollment information with the required NPI. Training will also need to be developed and presented to these providers on how to submit claims with this new identifier.

Although no guidance has been issued surrounding the type of system to report and disclose adverse actions taken against those providers who are terminated from the Medicaid program, it is reasonable to expect significant time and resources will be spent on the design and implementation of the system. The regulations surrounding the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary have yet to be released.

Several policy changes will need to be made with respect to the new application fee. This will include notification to providers, as well as the Medicaid program's accounting unit needing to develop a process to handle these new revenues.

Applicability to Nevada: Nevada will be directly affected by the various provisions set forth in Sections 6401, 6402, 6501, and 6502. To begin with, and as stated above, the new provisions surrounding Provider Enrollment Screening/Provisional Enrollment/Moratoriums will require significant staff resources in order to develop new policies to carry out these new provisions. Also, NPIs are not currently mandated for select providers throughout Nevada. Consequently, DHCFP will need to provide ad-hoc lists of providers without NPIs.

Moreover, the current data matching into MSIS is back-logged and is transmitted approximately one to two years after the recipient encounter. It is imperative to have dedicated resources to address these systems issues. With regard to permissive exclusions and exclusion regulations, current systems limitations prohibit a computerized search of data captured from the enrollment application and will need to be examined on an individual, manual basis.